STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Nursing and Rehabilitation Center	800 Chambers Road Ferguson, MO 63135

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34926 See 81JV12 Based on interview and record review, the facility failed to respond to a report that the Business Office Manager (BOM) had been placed on the Employee Disqualification List (EDL, a listing of individuals disqualified from working in a certified nursing home) indicating he/she was ineligible to work in a certified long-term care facility, and continued to employ the staff member. The Department of Health and Senior Services (DHSS) notified the facility on 10/30/24 at 11:45 A.M., that the BOM was permanently placed on the EDL on 10/22/24, and he/she was still working at the facility when surveyors began the investigation on 11/14/24. The census was 95. Review of the EDL Active Report, showed: -The BOM's name and Social Security Number; -Added: 10/22/24; -Ordered Length: Permanent. During an interview on 11/14/24 at 1:41 P.M., the Human Resources (HR) Director said he/she was not aware the BOM had been placed on the EDL. No one notified him/her of the placement. The BOM was currently employed by the facility and had worked as recently as the previous day. The BOM was out of the facility currently due to an emergency. The HR Director has only been in this position since August and had not been able to do quarterly EDL checks. During an interview on 11/14/24 at 1:55 P.M., the Administrator said he was not aware the BOM was placed on the EDL. No one notified him of it until approximately five minutes prior. He checked his phone and there were no voicemails to that effect. The BOM was in the facility working this morning, but said he/she was in pain and needed to leave around the same time as DHSS entered the facility. The BOM is scheduled to have surgery on November 25th, so he did not think twice about it. He was aware screenings needed to be completed post-hire. He understood they were needed to ensure staff were not on the EDL. The HR Director had only been in the position for a few months. He was not sure how often the HR Director was checking the EDL. The EDL was checked, and the BOM was on the list. He will call and terminate him/her immediately. He had been unaware of his/her placement on the EDL. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 1:35 P.M., the HR Director said no one called and told him/her the BOM was placed on the EDL. If someone called, they did not speak with him/her. He/She just started at the end of August and is still trying to clean up things. He/She performed a facility-wide EDL check yesterday and would be checking them quarterly from this time forward. During an interview on 11/15/24 at 10:40 A.M., the Administrator said he called and terminated the BOM the previous evening. He formally educated the HR Director on the importance of EDL checks and the protocol for how often to check it. An EDL check was run on all facility employees with no other issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27723 See 81JV12 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors. Staff failed to discontinue a medication used to lower blood sugar as ordered for one resident (Resident #13). The census was 95. Review of the facility's Medication and Treatment Orders Policy, dated 7/2016, showed the following: -Policy: Orders for medications and treatments will be consistent with the principles of safe and effective order writing; -1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such such medication in this state; -3. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart; -4. All drug and biological orders shall be written, dated and signed by the person lawfully authorized to give such an order; -9. Orders for medication must include: a. Name and strength of the medication. b. Number of doses, start and stop date and or specific duration of therapy. c. Dosage and frequency of of administration. d. Route of administration. e. Clinical condition or symptoms for which the medication is prescribed. f. Any interim follow up requirements. Review of the facility's Administering Medications policy, updated 4/2019, showed the following: -Medications are administered in a safe and timely mannered as prescribed; -Medications are administered in accordance with prescriber orders, including any required time frames. Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/24, showed the following: -Diagnoses of diabetes, high blood pressure and Parkinson's disease (a chronic brain disorder that affects movement, balance, and coordination); -Required total assistance of staff for personal hygiene, bathing, dressing and toileting; -Incontinent of bowel and bladder; -Medication: Received insulin injection in the last seven days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, dated 9/20/24 at 8:39 A.M., showed the following: -Resident lay in bed. Poor response. Blood Sugar 81 (normal range, 70 and 100 milligram (mg)/dL); -Grabbing and holding on to staff; -Physician in the facility, new orders for urinalysis and blood work; -Resident refused to open mouth, tremors noted; -New order to send resident to the hospital for evaluation. Review of the resident's Hospital Admission Orders, dated 9/20/24, showed the following: -admitted : 9/20/24; -admitted for altered mental status. Blood glucose noted to be 45; -Given 200 milliliters (ml) of D 10 (10% Dextrose (intravenous fluid with sugar, used for patients with low blood sugar) enroute to the hospital. Review of the resident's Hospital Transfer Orders, dated 9/25/24, showed the following: -Discharge diagnosis: Hypoglycemia (low blood sugar); -Stop taking this medication: Metformin (medication used to lower blood sugar). Review of the resident's Physician's Order Sheet (POS), showed the following: -admitted [DATE]; -Diagnosis of diabetes; -Metformin 500 milligram (mg) one tablet by mouth twice a day; -Administer Glucagon 1 mg for blood sugars less than 60. Review of the resident's readmission progress notes, dated 9/25/24, showed the following: -Returned to the facility; -Physician notified of return; -No new orders; -No documentation regarding the Metformin. Review of the resident's Medication Administration Record (MAR), dated 9/24, showed the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Metformin 500 mg two time a day. Start date 8/16/24. Discontinued 9/26/24; -Staff documented medication administered on day shift 9/26/24. Review of the resident's care plan, updated 9/25/24, showed the following: -Problem: Has diagnosis of diabetes mellitus; -Goal: Will be free from signs/symptoms of hypoglycemia (low blood sugar), hyperglycemia (high blood sugar), will be free from diabetes complications. -Intervention: Diabetes medication as ordered by the physician. Monitor and document side effects and effectiveness. Review of the resident's progress notes, dated 10/2024, showed the following: -10/16/24 at 7:33 P.M.: Blood Sugar 40; -Orange juice, glucose tablet and fudge brownie given; -Blood sugar rechecked after 20 minutes: 107. Review of the resident's MAR, dated 10/24, showed the following: -Metformin 500 mg two time a day. Start date 9/26/24; -Staff documented medication administered at 8:00 A.M. on 10/1 through 10/31/24; -Staff documented medication administered at 5:00 P.M. on 10/1 through 10/31/24. Review of the resident's MAR, dated 11/24, showed the following: -Metformin 500 mg two time a day. Start date 9/26/24; -Staff documented medication administered at 8:00 A.M. on 11/1 through 11/15/24; -Staff documented medication administered at 5:00 P.M. on 11/1 through 11/14/24. Review of the resident's progress notes, dated 11/14/24, showed the following: -Blood sugar: 51. Glucagon 1 mg given for blood sugar less than 60; -Physician notified, new order to reduce Levemir (insulin) to 15 units every evening. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/15/24 at 9:50 A.M., showed the resident lay in bed. Certified Nurse Aide (CNA) OO raised the head of the resident's bed and attempted to feed him/her breakfast. The resident was slow to respond and held food in his/her mouth. CNA OO reported to the nurse the resident held food in his/her mouth. The nurse checked the resident's blood sugar which was 66. He/She gave the resident orange juice with sugar at this time. He/She rechecked the blood sugar after 15 minutes, which showed a blood sugar of 83. During an interview on 11/15/24 at 1:35 P.M., the Director of Nurses said staff failed to discontinue the Metformin as ordered on the hospital discharge orders. She was unaware the Metformin wasn't discontinued as ordered. The nurse who was responsible was discharged due to another error. The physician has been notified and the Metformin was discontinued.